DCH-LMD-95 (03/04)

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

MEDICAL RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send original applications, with the proper fees, to the Board of Medicine. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Submit the required 150 hours of board-approved continuing education, with at least 75 of those hours in category 1 credits, earned within the 3 years preceding the date of the application for relicensure. Additional information about the continuing education requirements for Michigan are available on-line at www.michigan.gov/healthlicense.

3. Each state in which you hold or have ever held a permanent MD license must submit verification of licensure directly to the Board office. The attached Verification of Licensure Form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. Please submit the attached controlled substance license application with the $85.00 fee. A controlled substance license is required for every licensee who manufactures, distributes, prescribes, or dispenses any controlled substance in Michigan.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Medicine in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Medicine in writing to request a refund.

SINCE ALL MEDICINE LICENSES EXPIRE ON JANUARY 31, ORIGINAL LICENSES ARE VALID TO THE FIRST JANUARY 31 WHICH MAY BE A YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (01/05)

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Board Use Only
Date of Licensure
License Number

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

DCH/LMD-094 (01/04)

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued

Evidence that you have earned 150 hours of continuing medical education (CME) in the three years preceding this application, including a minimum of 75 hours in Category (1), must be submitted with this application.

NOTE: Relicensures will expire on January 31 of the following year. Subsequent renewals are for a three year period.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **Relicensure Fee: $170.00 71-4301-06**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date:

Street Address

City	State	ZIP Code

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)

Has your Michigan medical license been lapsed more than three years?

☐ Yes ☐ No

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ **Yes**	☐ **No**
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ **Yes**	☐ **No**
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ **Yes**	☐ **No**
4. Have you been treated for substance abuse in the past 2 years?	☐ **Yes**	☐ **No**
5. Have you ever been warned, censured, or requested to withdraw from a health care facility's staff or had your heath care facility staff privileges modified?	☐ **Yes**	☐ **No**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ Yes ☐ No

7. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ Yes ☐ No

8. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No

List each state(s) in which you hold or have ever held a permanent medical license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each state board verify license directly to this board office. (Attach additional sheets if necessary)

State	License Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.) ☐ Endorsement - Please indicate name of state		
License Status ☐ Current ☐ Lapsed ☐ Inactive	**Original Issue Date**	**Expiration Date**

Has the applicant incurred any formal or informal actions in your State?

☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.